
Decision-making competence in adults: a philosopher's viewpoint

Donna Dickenson

What does it mean to respect autonomy and encourage meaningful consent to treatment in the case of patients who have dementia or are otherwise incompetent? This question has been thrown into sharp relief by the Law Lords' decision in *R.v Bournemouth Community and Mental Health NHS Trust, ex parte L* (1998). The effect of the Law Lords' ruling in the Bournemouth judgment is to reinforce problematic and serious anomalies in the way we view patients whose competence is in doubt because of their mental disorder. Others, such as relatives and informal carers, are frequently allowed to decide on behalf of adults whose competence is doubtful in a way that English law generally abhors, even for totally incompetent patients in a persistent vegetative state. This raises profound questions about autonomy. And incompetent adults' consent to treatment is not required to be of the same quality as it is for the rest of us: mere absence of resistance will do. This paper will explore the philosophical, jurisprudential and legal implications of this difference. Throughout I will be more concerned with the ramifications of a finding of incapacity than with how such a finding is made (for the latter, see such classic texts as Applebaum & Roth (1982), Grisso & Applebaum (1998) and Bellhouse *et al* (2001)).

Relatives' consent v. patient autonomy

Following the Law Lords' ruling, the agreement of the nearest relative remains sufficient for informal admission to hospital, in the case of an incompetent

patient such as Mr L. Yet English law otherwise upholds individual autonomy very strictly – by refusing to recognise proxy consent or substituted judgement by relatives or friends, in situations where competence is not obvious (Montgomery, 1997). Although it is good practice to consult 'significant others' about what the incapacitated patient might want, it is not necessary or binding in law (*Re T*, 1992). The law does not actually put this point in terms of personal autonomy, but a more philosophical way of understanding the absence of proxy consent is in terms of an extremely atomistic, individualistic model of the person in society. Our law's insistence on this point differs from most other jurisdictions, even many US states – where one might actually expect the autonomy of the individual to be a stronger fixation than in the UK (Buchanan & Brock, 1989; Eiseman *et al*, 1999; Hillery *et al*, 1999). For example, in the case of patients in a persistent vegetative state, life-support cannot be withdrawn simply on the say-so of a relative; instead, the standard in such cases is the best interest of the individual concerned; in the absence of an advance directive, application must be made to the High Court (*Airedale NHS Trust v Bland*, 1993; British Medical Association (BMA) & Law Society, 1995). In other end-of-life cases, doctors may be authorised to act in the patient's best interests alone, according to BMA guidelines on withholding and withdrawing treatment (BMA, 1999). But the law still maintains that the opinions of relatives are not determinative, although it may be good practice to consult with them.

The effect of the Law Lords' decision about informal admission in the Bournemouth case, one might argue, is to sanction the treatment of people

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with dementia, learning disability or autism as 'beyond the pale' of our law's general unwillingness to let others consent on an adult patient's behalf, even on behalf of an incompetent adult. A patient in a persistent vegetative state, whose lack of capacity is not in doubt, is still treated as a strictly autonomous individual in so far as no one else is allowed to give or withhold consent to treatment on his or her behalf. But in the case of an informally admitted patient like Mr L, whose capacity is doubtful but by no means as doubtful as in the persistent vegetative state example, it looks as if others *are* allowed to decide on his behalf. This seems to contradict the general principle in English law that no one can give or withhold consent on behalf of an adult patient, reducing Mr L and other such patients to the status of children. Furthermore, whereas consent is generally presumed to be active, the Bournemouth case confirms that mere absence of resistance is enough in the case of an informally admitted patient without capacity. How did this puzzling situation come about? And does it make logical sense?

The Bournemouth judgment

The Law Lords' judgment overturned the ruling of the Court of Appeal (2 December 1997) that Mr L, a man with severe autism and profound learning difficulties, had been unlawfully detained by Bournemouth Hospital Trust. But the judgment is unlikely to be the last we hear of the serious issues raised by this case, either in the European courts or in domestic statutory reform. One of the Law Lords, Lord Steyn, expressed his concern that "The general effect [of the Law Lords' judgment] ... is to leave competent incapacitated patients without... safeguards," even though he felt he had no alternative but to rule against Mr L under existing law. "The only comfort," he continued, "is that counsel for the Secretary of State has assured the House that reform of the law is under active consideration." (This comment probably refers to the Richardson Committee's activities (Department of Health, 1999a) and the subsequent Green Paper proposing the Government's own proposals for reform of the Mental Health Act 1983 (MHA) (Department of Health, 1999b). However, reform of informal admission procedures does not appear to play a major part in the Government's plans, which are more concerned with protecting the community from discharged patients who may still pose a risk (Laing, 2000).)

Before the Bournemouth decision in the Court of Appeal, psychiatrists had relied heavily on informal admission for patients like Mr L, rather than use of

the formal procedures under the MHA (Shah & Dickenson, 1998). For patients admitted informally, legality of treatment depended on the general rules covering consent under common law, rather than statutes such as the MHA. (There are in fact some limited protections under the MHA for informally admitted patients, e.g. no psychosurgery or hormonal implants.) But according to the decision in the Court of Appeal, under both Section 131 of the MHA (concerning informal admission) and common law, only those patients who are competent to consent can do so. This was the crux of the difficulty: those incompetent to consent cannot give meaningful consent under common law, but if admitted informally, their civil rights are not protected under the MHA.

This was the case with Mr L, a 48-year-old man with autism, learning disability, a history of fits, temporal lobe abnormality and complex needs requiring 24-hour care. Unable to speak, with no ability to communicate consent or dissent to hospital admission, Mr L became agitated at his day centre, banging his head violently and repeatedly against the wall. Although his foster carers could control his behaviour, they could not be contacted at the time. A local doctor administered a sedative, and Mr L was taken by ambulance to the accident and emergency department at Bournemouth Hospital. As the sedative began to wear off, he became agitated again and was transferred for in-patient treatment at the hospital's behavioural unit, where he had previously resided for 30 years. His foster carers, with whom he had lived for 4 years, were not allowed to see him while his needs were being assessed, on the grounds that he might attempt to leave with them before he was fit for discharge, although Mr L had not made any attempt to resist admission. The carers, Mr and Mrs E, applied to the High Court for judicial review of the trust's decision to detain Mr L, seeking a declaration that his detention was unlawful and an order that he should be released forthwith.

Although the High Court found in the hospital's favour, the Court of Appeal held that Mr L had indeed been unlawfully detained and ordered his release into the care of Mr and Mrs E. Informal admission, as Lord Woolf M.R., Phillips and Chadwick L. JJ. stated, requires active consent, not the mere absence of open resistance. A person who lacks capacity to consent or dissent must be admitted under the statutory procedures of the MHA, it was held. As an informal patient, Mr L had been denied the safeguards built into the Act, such as the right to apply to an independent tribunal for discharge. In fact, after the initial Court of Appeal hearing and pending the final judgment, the trust had thought it prudent to formally detain Mr L under Section 3 of

the MHA. Throughout England and Wales (the judgment did not apply to Scotland) hospitals were advised to do the same, by the National Health Service (NHS) Executive, the Royal College of Psychiatrists and the Department of Health. It was feared that full implementation of the decision would result in a threefold increase in the number of detained patients (Livingston *et al*, 1998: p. 402).

The Court of Appeal had held that Mr L could not be treated under the principle of necessity – which allows unconscious casualty admissions, for example, to be treated without consent – when there was a valid statute ready and waiting to be used instead. In their judgment of 25 June 1998 the Law Lords disagreed. Lord Goff noted that “The decision of the Court of Appeal has caused grave concern” and that “It was obvious that there would in the result be a substantial impact on the available resources” – although the case was not overtly, at least, decided on resource issues. The questions were whether Mr L had been unlawfully detained and whether the principle of necessity could apply: the first a point of fact, as Lord Steyn noted, and the second a matter of law.

Was Mr L unlawfully detained?

The Law Lords disagreed over whether Mr L had in fact been detained against his will. Lords Goff and Lloyd found that he had not been held without his consent, although he had been physically conveyed to Bournemouth Hospital and although the duty psychiatrist made it plain that she intended to detain him under the MHA if he resisted admission. The issue was the tort (or wrong) of false imprisonment, for which there must be complete deprivation of the person’s liberty in actual fact, not as a hypothetical intention. Mr L had been accommodated on an unlocked ward, and had never attempted to leave, so that there was no tort of false imprisonment. This reasoning was rejected by Lord Steyn as “stretching credulity to the breaking point”. Mr L had been sedated repeatedly in hospital and closely monitored by nursing staff, even though the ward was unlocked. “The suggestion that L was free to go is a fairy tale,” Lord Steyn declared categorically. “In my view L was detained because the health care professionals intentionally assumed control over him to such a degree as to amount to complete deprivation of his liberty.”

Lord Goff argued that Mr L had never been finally discharged from Bournemouth Hospital, only sent to live with Mr and Mrs E on a trial basis. Therefore

the trust remained responsible for his treatment, and any steps taken to detain him were in discharge of its duty of care. Whether or not Mr L had in fact been detained was a separate matter from the justification for detaining him, that is, the trust’s duty of care. It could actually be rightful, indeed obligatory, to detain him for that purpose, Lord Nolan argued.

Necessity and best interests

This leads into the second reason that the Law Lords gave for overturning the Appeal Court decision: the psychiatrists were justified in their action by the common-law doctrine of necessity. That is, they were justified in taking measures that they judged to be of therapeutic benefit, in L’s best interests, for as long as it was not practicable to communicate with him, and provided that the actions were those a reasonable person would have taken in the circumstances. (The doctrine of necessity may also be used to treat patients with physical illness (such as unconscious emergency admissions to hospital); it is not unique to psychiatry (Szmukler & Holloway, 1999)). It was against this common-law background, according to Lord Steyn’s opinion, that the mental health legislation must be understood. The Percy Report of 1957, which laid the basis for the Mental Health Act 1959, marked a shift from the older legalism under which all patients had to be ‘certified’ before being admitted, to a situation in which most patients would be received informally (see also McGarry & Chodoff, 1981). The ideal was that there should be “the offer of care, without deprivation of liberty, to all who need it and are *not unwilling to receive it*” (my italics).

Here, then, is the statutory basis for the ethically dubious practice of equating lack of resistance with active consent to treatment. Compulsion was to be regarded as a measure of last resort, so that as many patients as possible would be treated, and treated without the stigmatisation of formal procedures. To this end the MHA 1959 stipulated in Section 5 (1), on informal admission of patients, that

“Nothing in this Act shall be conceived as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act.”

The MHA 1983 reproduced this clause verbatim as Section 131 (1).

In other words, this is a sort of mopping-up clause that allows a patient to be admitted informally and treated under the doctrine of necessity, if that is

judged to be in his or her best interests, regardless of whether or not doctors choose to invoke formal procedures. Despite his view that Mr L had been unlawfully detained and his fear that informally admitted patients were denied the safeguards afforded to compulsory patients, Lord Steyn was forced to conclude that the Court of Appeal had erred:

“The conclusion cannot be avoided that Section 131 (1) permits the admission of compliant incapacitated patients where the requirements of the principle of necessity are satisfied.”

But is the Percy Report's emphasis on maximising patient numbers by informal means still relevant? In clinical experience since the Court of Appeal judgment and the ensuing NHS Executive circular advising that informally admitted patients should be formally detained instead, Shah & Dickenson (1998) have found that relatives of patients who have been formally detained are reluctant to see the detention order rescinded once the Law Lords' judgment allowed it to be. Rather than being pleased that their family member can be cared for informally, without the supposed stigmatisation of 'sectioning', they feel that they and their relative enjoy better rights under the MHA. This admittedly anecdotal finding from clinical experience bears out Lord Steyn's concern that the restoration of informal admission in the absence of overt dissent creates an “indefensible gap” in mental health law – the position also taken by an editorial in the *BMJ* (Eastman & Peay, 1998; comment by Dickenson & Shah, 1999).

The Government's proposals in *Making Decisions*

There are indications that the Percy Report's approach is indeed out of date and that Lord Steyn's urgent wish to see the law changed may well be fulfilled. In addition to the Richardson Commission's deliberations on reforming the MHA, new statutory legislation on incapacity is now planned. In October 1999 the Lord Chancellor's Department published *Making Decisions*, containing the Government's proposals for legislation on mental capacity in England and Wales (Lord Chancellor's Department, 1999) – the final product of a series of Law Commission consultations (summarised in Law Commission, 1995) and a further government consultation document, *Who Decides?* (Lord Chancellor's Department, 1997). (The Scottish Executive published a similar

programme of legislative action in August 1999, resulting in the Adults with Incapacity (Scotland) Act 2000.)

Do these long-awaited proposals on incapacity solve the puzzles about autonomy, capacity and consent left by the Bournemouth decision? The remainder of this paper evaluates this question under those three headings.

Autonomy

It does appear that the proposals in *Making Decisions* add up to a less atomistic view of patients in general and of the incompetent patient in particular. The traditional common-law position, restated only in the BMA guidelines on withdrawal of treatment, allows no middle ground between deferring to the wishes of the competent patient, whose autonomy is virtually absolute within the limitations of clinical judgement, and resorting to the more paternalistic notion of best interests in the case of the incompetent patient. The new proposals on a statutory definition of best interests, however, allow a specific role to the views of relatives and other carers in the checklist to be followed in determining what constitutes the patient's best interests. The list of factors to be followed (although “it should not be applied too rigidly” (S. 1.15)) also emphasises “the ascertainable past and present wishes and feelings of the person concerned” (1.11), echoing the language of the Children Act 1989 checklist for guidance in decisions about the welfare of children and young people (White *et al*, 1990). In short, we may be seeing a less dualistic and clear-cut divide between the individualistic model applied to the patient with capacity and the paternalistic ‘best interests’ criterion by which doctors decide on behalf of incompetent patients.

Two other innovations in *Making Decisions* have a similar effect and also lessen the effect of the Bournemouth decision in treating patients without capacity as beyond the pale of our law's general unwillingness to let informal carers have any say in the patient's treatment. For patients who are competent now, but fear that they may lose capacity (e.g. patients in the early stages of dementia) it will be possible to delegate decision-making on health care treatment to a named proxy through a Continued Power of Attorney (2.4). Although the named attorney will never be able to consent to the donor's compulsory treatment under the MHA, he or she might be able to consent or withhold consent about voluntary admission, rectifying the “indefensible gap in mental health law” arguably

left by the Bournewood decision. What the attorney will be able to do – which has previously been possible only in financial matters – is to make general health care decisions on the basis of his or her estimate of what the now-incompetent patient would have wanted. Philosophically speaking, this too marks a move away from the atomistic view of the individual; instead, it accepts a model of individuals in relationship that has been urged for many years by feminist bioethicists (e.g. Held, 1993). It sites the individual legitimately within the family, rather than viewing the family as a hindrance to clinicians (Lindemann Nelson & Lindemann Nelson, 1995).

The proposals for a Continued Power of Attorney would not have helped Mr L, because he never had capacity. But he might have benefited from the possibility of a court-appointed personal manager, the case for which is set out in other provisions of *Making Decisions* (3.22 and 3.23). It is not at all clear, however, that someone like Mr E will be allowed in future to refuse admission on behalf of Mr L, even if he can get himself appointed by the court. The majority of respondents to the Law Commission consultative exercises and the *Who Decides?* document opposed allowing a court-appointed personal manager to refuse consent to health care, although the Law Society and Age Concern were among the “substantial minority” in favour (3.22). The Government is assuming that “In most health-care cases, a one-off decision about treatment will be needed. This could be made by the court without the need to appoint a manager.” Arguably, this applies more to acute medicine than to psychiatry. None the less, the Government has not firmly ruled out the possibility of a personal manager for someone like Mr L – again, possibly allowing a proxy to decide.

Capacity

The proposals for legislative action in *Making Decisions* take a functional approach to capacity, consistent with a common approach from the earliest Law Commission consultations dating back to 1991. That is, capacity is to be measured by whether the individual can make this particular decision, at this particular time. Capacity is not viewed as an all-or-nothing quantity that some people will always have and some people will forever lack. Just as the Gillick decision (*Gillick v W. Norfolk & Wisbech Area Health Authority*, 1985) helped to break down the dualistic divide between competent adults and incompetent children, stating that a young person under 18 who

is capable of understanding the nature and ramifications of treatment could give meaningful consent regardless of her parents' wishes, so the proposals in *Making Decisions* undermine any hard-and-fast divide between competent and incompetent adults. Again, this strikes a blow against medical paternalism.

However, the proposals do let paternalism in by the back door, just as subsequent case law (e.g. *Re W*, 1992) has done in relation to children's competence to refuse treatment. This happens in a rather subtle manner, relating to the *quality* of the decision as judged by a court or other decision-making body. After stipulating that the best interests of a person without capacity must weight in “the ascertainable past and present wishes and feelings of the person concerned”, Section 1.11 of *Making Decisions* immediately backtracks by adding “and the factors that the person would consider if able to do so”. Clearly there is a risk that these factors will be those that the person making the decision on behalf of the incompetent person would have taken into account. In other words, although *Making Decisions* does explicitly say that the decision need not be prudent (1.9) there is a ‘catch-22’ here. “If able to do so”, it may well be assumed, the person without capacity would have considered all the factors that go towards making a prudent decision, or at least a decision that professionals caring for him or her find prudent. Therefore there is a risk that any decision that does not conform to professionals' own standard of prudence may not be viewed as reflecting the ‘true wishes’ of the incompetent patient. (A similar problem concerning children's ‘true wishes’ is explored in some detail in Dickenson & Jones (1995).)

There is a tension between Section 1.11 and the firm provision in Section 1.9 that a person whose capacity is in doubt “should not be regarded as incapable [of making his own decisions] because the decisions he reaches appear to others to be unwise or irrational”.

One way of resolving the tension is to distinguish between the decision itself (which need not be sensible *prima facie*) and the diligence with which it is made. But this distinction is not always easy to make, of course. At any rate, the Government's proposals are certainly less paternalistic than the definition that was at one point being considered by the Richardson Committee:

“A person lacks capacity where, although intellectually able to understand and apply the information, that person none the less reaches a judgement which he or she would not have reached in the absence of mental disorder. Such a judgement can be said to be primarily a product of the disorder and not to reflect the person's true preferences.”

Consent

The issue of whether a person without capacity must give active consent to treatment and admission, or whether absence of dissent is enough, is not explicitly covered in *Making Decisions*. This may seem surprising and troubling, given the importance of the Bournemouth case and the manner in which it appears to allow absence of dissent as 'good enough'. However, it is probably fair to say that the document generally envisages a more active role for adults incapacitated by mental illness. For example, it emphasises that "All practicable steps must be taken to enable a person without capacity to communicate their decisions" (1.6). Similarly, the checklist for assessing best interests includes

"the need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her" (1.11).

It remains to be seen whether any subsequent legislation, and its interpretation in case law, will eventually be extended into requiring an active consent to treatment, putting incapacitated persons on a level with other adults and reversing the effect of Bournemouth.

Conclusion

I argued at the beginning of this paper that the effect of the Bournemouth decision was to treat informally admitted patients without capacity as significantly different from all other adults, including the comatose, in so far as relatives' decisions can determine their fate. Furthermore, whereas consent is generally presumed to be active, the Bournemouth case confirms that mere absence of resistance is enough in the case of an informally admitted patient without capacity. One might argue that this is exactly the reverse of what ought to apply, given that psychiatrists are perhaps required more often than are other sorts of doctor to treat patients who do not consent (Dickenson, 1997).

The effect of these two provisions, I argued, was to place incapacitated patients beyond the pale of how English law generally conceptualises the adult individual, whose rights of self-determination are firmly rooted. The new proposals on a statutory definition of best interests likewise allow a specific role to the views of relatives and other carers in the checklist to be followed in determining what constitutes the patient's best interests. They also

allow paternalism in through the back door, by permitting consideration of factors that the patient would have taken into account if competent. However, one might also argue that they are beneficial to the autonomy of the incapacitated in their provisions about a personal manager and in the explicit statement that the treatment decision that an incapacitated patient reaches need not be rational or prudent.

Put simply, the provisions in *Making Decisions* pull two ways: towards autonomy in one direction and paternalism in the other. The same can be said, more generally, of the tension between the more patient-centred proposals of the Richardson Commission and the Government's more 'law-and-order' minded proposals for reform of the MHA (Laing, 2000: p. 219). It remains to be seen which strand will predominate in whatever legislation is finally passed.

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Re W [1992] 4 All ER 627.

* indicates articles of particular interest

Multiple choice questions

- The Bournwood case concerned a patient who was:
 - incompetent because of being in a persistent vegetative state
 - a mentally disordered violent offender who might pose a risk to others
 - incapacitated through autism and learning disability
 - under the legal age of capacity.
- Informal admission to psychiatric care for a patient lacking capacity may be justified on the basis of:
 - consent, under common-law principles, from the patient
 - use of the MHA
 - consent, under common-law principles, with permission from the nearest relative
 - a court order.
- Valid consent to admission, in the case of a mentally incapacitated patient, means:
 - active verbal agreement with the clinician's opinion
 - absence of dissent from the clinician's opinion
 - apparent agreement expressed through gestures or other non-verbal means
 - understanding, believing and weighing up the relevant information.
- The Government's new proposals in *Making Decisions* include:
 - a Continuing Power of Attorney for making health care decisions on behalf of incapacitated patients
 - a Continuing Power of Attorney for making only financial decisions, not health care decisions
 - allowing a named attorney to consent to compulsory admission under the MHA in the case of a patient who was competent but has now lost competence
 - allowing a named attorney to consent to compulsory admission under the MHA in the case of patients who have never had capacity.
- The best interests of the incapacitated person, according to the Government proposals, can be judged to include:
 - factors the person would consider if able to do so
 - only those factors that the incapacitated person herself understands to be in her own best interest
 - factors that relatives feel to be in the patient's best interest
 - physical treatment only, not treatment for mental disorder.

MCQ answers

1	2	3	4	5
a F	a F	a F	a T	a T
b F	b F	b T	b F	b F
c T	c T	c F	c F	c F
d F	d F	d F	d F	d F